DOCUMENTATION AND WORK RELATED INJURY REPORTING

Sometimes things happen which may result in a near miss, an injury or an incident to an employee. When this happens, it is important that these situations are documented properly for review by the supervisors and management of ISDA to monitor the safety and loss control program. Additionally, claim reports need to be complete in the event an injury requires an employee to seek medical treatment.

- Documenting near misses and incidents should be done immediately. Employees should be required to notify supervisors and advise them of any incident or near miss that occurred.

- Supervisors may use the Supervisor's Accident Report form (SIF 17-82 Rev. 2/01)1 to document such occurrences.

- This Supervisor's Accident Investigation Report form should be held on file for review by the agency's safety and loss control group or committee. Any trends found, such as numerous tripping cases in the same area, should be thoroughly investigated and actions taken to correct any problems found to reduce the risk of an injury requiring medical treatment.

- A First Report of Injury (FROI) must be completed by the supervisor for any employee that is injured on the job, during the course and scope of his/her job duties, and requires medical attention or misses more than one (1) day from work as a result of these injuries. This report form can be found online at http://www2.state.id.us/isif/forms/froi.pdf . If you do not have access to the Internet, paper copies of the FROI are available from the ISDA Human Resource Office. Any questions regarding the claim should be referred directly to the State Insurance Fund.

Workers Compensation – First Report of Injury or Illness

State Insurance Fund e-mail form – return as an e-mail attachment to reportclaim@isif.state.id.us. Do not mail a copy of a printed form.

Every work injury that requires medical services other than first aid treatment must be reported within **TEN** days after the employer has knowledge of the injury. **Filing this form is not an admission of liability**. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made.

EMPLOYER

Employer's name:	Employer status ☐ Sole Proprietor ☐ LLC ☐ Public ☐ Partnership ☐ Corporation ☐ Other
Address:	
City: State: ZIP:	
Phone #: FAX # :	Is injured worker a Corporate Officer, Partner, LLC member or Sole Proprietor? ☐ Yes ☐ No
Employer's location address (if different)	
Address:	If a Sole Proprietorship, is the injured worker a household member? ☐ Yes ☐ No
City: State: ZIP:	
Policy number:	Organization code:

EMPLOYEE

Employee's last name:	State where hired:
Employee's first name:	Occupation:
Address:	Employment status:
City: State: ZIP:	Sex ☐ Female ☐ Male
Phone # :	Social Security # :
Date of birth:	Date hired:
Under what class code were wages reported?	Injury date:
Regular department:	Marital status ☐ Single ☐ Widowed ☐ Other ☐ Married ☐ Separated

WAGES

Wage rate $ per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Other		Hours worked per week:
# of days worked per week:	Full pay for the day of injury? ☐ Yes ☐ No	Did salary continue? ☐ Yes ☐ No
If board, lodging or other advantages furnished in addition to wages, give estimated value per week. $		
If gratuities (tips, etc.) were received in the course of employment, give estimated value per week. $		

ACCIDENT OR ILLNESS

Place of accident or exposure (address):		City/State:
County:	Did injury/illness occur on the employer's premises? ☐ Yes ☐ No	
Time injury occurred: ☐ AM ☐ PM		Time employee began work: ☐ AM ☐ PM
Date last worked:	Date employer notified:	Date disability began:
Date returned to work:	If fatal, date of death:	Injury type (strain, cut, etc.):
Part of body affected:		Body part injured before? ☐ Yes ☐ No
Injury reported to (name and phone #) :		
Equipment, materials, or chemicals employee was using upon occurrence:		
How injury or illness occurred (Describe the sequence of events. Include objects or substances that directly caused the injury)		
Was accident caused by the failure of a machine or product? ☐ Yes ☐ No		Was safety equipment provided? ☐ Yes ☐ No
If the accident was caused by any person or business other than the injured worker, co-worker or the employer, please identify.		Was it used? ☐ Yes ☐ No
		Were other workers also injured? ☐ Yes ☐ No
		List other workers' names:

MED

Physician or hospital (name and address)	☐ No medical treatment ☐ Minor by employer ☐ Minor – clinic/hospital ☐ Emergency care ☐ Anticipated major med/time loss ☐ Hospitalized overnight

Did anyone witness the accident? ☐ Yes ☐ No If yes, provide name, phone # :	
Preparer's name and title:	
Preparer's phone number:	Date prepared:

E-mail this as an attachment to reportclaim@isif.state.id.us. Employers *do not* need to e-mail this form to the Industrial Commission. Employers should keep a copy on file.